MEDICAL HISTORY QUESTIONNAIRE

Name:____ Date:_______________

Date of Birth:_______________________________________ Date of last eye exam:________________________________

List any medications you currently take (prescription and over the counter): ____________________________________
____

Do you have allergies to any medications? YES NO List any medications or other allergies: ______________________
____

List any major illnesses (glaucoma, diabetes, high blood pressure, heart attack, etc.) or injuries (concussion, etc.)__________________
____

List any surgeries you have had (cataract, appendectomy): ____
____

Do you currently have any problems in the following areas? Details.	No	Yes	Details
Eyes (poor vision, eye pain, tearing, redness, etc.)			
General/ Constitutional (fever, heat, stroke, weight loss, weight gain, unusually tired)			
Ears, Nose, Throat (hard of hearing, stuffy nose, ear ache, cough, dry mouth)			
Cardiovascular (high BP, racing pulse, etc)			
Respiratory (congestion, wheezing, short of breath, etc.)			
Gastrointestinal (stomach upset, diarrhea, constipation, hernia, ulcer, etc.)			
Genital, kidney, bladder (painful urination, frequent urination, impotence, etc)			
Females Are you pregnant? Nursing?			
Muscles, Bones, Joints (joint pain, stiffness, swelling, cramps, arthritis, etc)			
Skin (pimples, warts, growths, rash, etc.)			
Neurological (numbness, headache, seizures, paralysis, etc.)			
Psychiatric (anxiety, depression, insomnia)			
Endocrine (diabetes, hypothyroid, etc.)			
Blood/Lymph (bleeding, cholesterolemia, anemia, blood transfusions, etc.)			
Allergic/Immunologic (sneezing, swelling, redness, itching, hives, lupus,etc)			

FAMILY HISTORY (MOTHER, FATHER, GRANDPARENT, SIBLING)

Has any member of your family had these diseases (circle all that apply)? YES NO UNKOWN

Blindness, Cataract, Glaucoma, Diabetes, Hypertension, Heart Disease, Stroke, Cancer, Thyroid Disease, Arthritis,

Other heritable disease:

SOCIAL HISTORY

Does your vision limit any activities of daily living (driving, reading, sports, work, etc.? YES NO

Have you ever had a blood transfusion? YES NO

Do you drink alcohol? YES NO If yes, how much? _________

Do you smoke? YES NO If yes, how much? _________ How many years?

Patient/ Parent Signature: ______________________________________ Date: ______________________

Physician Signature: ____ Date: ______________________

3910 North Campbell Avenue
Tucson, AZ 85719
520-323-2466

3055 West Ina Road
Tucson, AZ 85741
520-293-5353

PLEASE FILL OUT ALL INFORMATION COMPLETELY

LAST NAME______________________________________FIRST______________________________MI________________________

ADDRESS____CITY__________________STATE______ZIP___________

HOME PHONE#________________________CELL#______________________________ WORK#_____________________________

EMAIL: ____

DATE OF BIRTH_______/__________/_________ SEX: F M MARITAL STATUS:_______ SSN________________________

EMPLOYER____OCCUPATION_____________________WORK#_____________________

IF THE PATIENT IS UNDER 18 YEARS OLD:

LEGAL GUARDIAN NAME /ADDRESS:____

CITY/STATE/ZIP____PHONE#_____________________________

FATHERS NAME:_________________________ EMPLOYER________________PHONE#___________________ ☐ **CUSTODIAL PARENT**

MOTHERS NAME:_________________________ EMPLOYER________________PHONE#___________________ ☐ **CUSTODIAL PARENT**

EMERGENCY CONTACT

NAME____ PHONE#____________________RELATIONSHIP TO PATIENT___________

MEDICAL INSURANCE INFORMATION

*PRIMARY INSURANCE*____________________________________ID#_____________________________GROUP#______________

EMPLOYER_________________________COPAY$_____________________POLICYHOLDERS NAME:___________________________

POLICYHOLDERS BIRTHDATE______/_______/_______ SSN#____________________RELATIONSHIP TO PATIENT__________

*SECONDARY INSURANCE*____ID#_________________GROUP#______________

EMPLOYER__________________________COPAY$____________________POLICYHOLDERS NAME:___________________________

POLICYHOLDERS BIRTHDATE_______/________/________ SSN#________________RELATIONSHIP TO PATIENT__________

VISION INSURANCE INFORMATION

INSURANCE NAME___________________________________ID#______________________________GROUP#_______________

EMPLOYER_________________________COPAY$___________________ POLICYHOLDERS NAME:___________________________

POLICYHOLDERS BIRTHDATE_______/________/________ RELATIONSHIP TO PATIENT________________________________

PLEASE READ AND CHOOSE ONE

☐ **Yes, I am aware that my insurance may or may not pay for refraction (prescription) services and I will be responsible for the $50 charge. All Vision Plans will cover this charge.**

☐ **I am declining refraction services. MUST BE CHECKED TO NOT RECEIVE THIS TREATMENT**

REFERRING/PRIMARY CARE PHYSICIAN

PRIMARY CARE PHYSICIAN____PHONE#________________________________

first and last name please

REFERRING PHYSICIAN____ PHONE#_________________________________

I UNDERSTAND AND AGREE THAT, REGARDLESS OF MY INSURANCE STATUS, I AM RESPONSIBLE FOR ANY CHARGES INCURRED FOR SERVICES RENDERED, THE ABOVE INFORMATION IS TRUE AND CORRECT TO THE BEST OF MY KNOWLEDGE. I WILL NOTIFY YOU OF ANY CHANGE IN THE ABOVE INFORMATION.

DATE:______________________ **SIGNATURE OF RESPONSIBLE PARTY**____

SAM E. SATO, M.D / DR. BOBBIE JO SMALLEY

Notice of Privacy Practice

I ______________________________________ acknowledge that I have received a copy or viewed a copy
(Name of Patient)
located on the wall by the check in counter of SAM E. SATO, M.D.'S "**Notice of Privacy Practices'.**

This notice describes how Sam E. Sato, M.D. may use and disclose my protected health information, certain restrictions on the use and disclosure of my healthcare information, and rights I may have regarding my protected health information.

______________________________________ ______________________________________
(Signature of Patient, or Personal Representative) **(Date)**

____
(Relationship to Patient)

NO-SHOW POLICY

A "No show" is someone who misses an appointment without canceling it by 10:00 am one working day in advance.
No-shows inconvenience those individuals who need access to medical care in a timely manner.

A failure to present at the time of a scheduled appointment will be recorded in the patients' chart as a "no show". The first time there is a "no show", the patient will be sent a letter alerting them to the fact that they have failed to show up for an appointment and did not cancel the appointment. A copy of the letter will be placed in the patient file. **If there is a second "no show" the doctor reserves the right to not treat the patient anymore.**

______________________________________ ______________________________________
(Signature of Patient, or Personal Representative) **(Date)**

____
(Relationship to Patient)

Consent to Treat a Minor

I, ____(print name) am, the parent/legal guardian of

______________________________ (print patient name), who currently is a minor, whose date of birth is ___/___/___. I am giving written consent to treat my minor child, if I personally can not authorize treatment, my child can be treated if an adult accompanies my child at the time of treatment, with the exception of surgery or an invasive procedure.

______________________________________ ______________________________

Signature Date

Emergency Phone Numbers

____ ____

Home Work Cell Other